Michigan Long-Term Care Supports & Services Advisory Commission
Post Retreat Business Session, January 28, 2009

- Agenda
- DRAFT going to LTCSS Advisory Commission, Core Competencies for Certified Nursing Assistants and Hospice Aides
- Draft Administrative Recommendations for CNA/Hospice Aide Training Program 1.21.09
- PHI State Facts, Michigan's Direct-Care Workforce
- Memorandum Re: Proposed Recommendations to LTCSS Advisory Commission
- Draft Letter – Dear Legislators

MICHIGAN LONG TERM CARE
SUPPORTS & SERVICES ADVISORY COMMISSION

POST RETREAT BUSINESS SESSION
AGENDA
JANUARY 28, 2009

1. Workforce Development Workgroup Action Items:
   A. Draft Core Competencies for Certified Nursing Assistants & Hospice Aides + Framework for Desired State Legislation
   B. Draft State Administrative (Executive Branch) Recommendations for Certified Nursing Assistant & Hospice Aide Training Programs

2. Public Awareness Education & Consumer Participation in the System Workgroup Action Item: Memo on Draft Public Awareness & Education Campaign Recommendations

3. Commission 2009 State Budget Revenues Advocacy Letter Draft by Commissioners Slocum, Ewing and Chaney

4. 2009 Commission Meeting Schedule: Requested Change of Weekday + Possible Sites Choices & Decisions

5. Discussion of Business Session Actions' Incorporation into New OLTCSS-Commission Strategic Plan & Relationships

6. Next Meeting, Workgroup Announcements & Adjournment

DRAFT going to LTCSS Advisory Commission

Core Competencies for Certified Nursing Assistants and Hospice Aides

The following core competencies reflect the basic skills, knowledge, and abilities necessary for certified nurse assistants (CNAs) and hospice aides to provide high quality person centered care to individuals using the services of Michigan's licensed nursing homes, hospital long-term care units, county medical care facilities and hospice agencies. While specific procedures and approaches may vary by setting, the core competencies support a philosophy of care that honors and respects the individual resident or client's preferences, choices, and abilities.

Competency 1: Approach to Care and Role of the Assistant/Aide
CNAs and hospice aides will demonstrate the philosophy, values, and approaches that define person-centered care and recognize the various roles and responsibilities of a certified aide and the other members of the caregiving team in promoting the delivery of high quality person-centered care across the spectrum of individual acuity needs.

Competency 2: Relational and Communication Skills
CNAs and hospice aides will demonstrate a wide array of effective relational and communication skills and abilities, including the use of electronic records, while interacting with residents and clients, their families, and all other members of the caregiving team.

Competency 3: Knowledge and Skills
CNAs and hospice aides will demonstrate the knowledge and skills needed to implement individualized resident and client plans of care including personal care, restorative and rehabilitative care, nutritional needs, cognitive impairments, and end of life care in keeping with the resident's and client's independence, preferences, dignity, choices, and available technology.

Competency 4: Well-being and Safety
CNAs and hospice aides will support the physical, mental, and psycho-social well-being of residents, clients, and co-workers through the use of proven health and safety workplace practices in keeping with the individual's preferences.

Competency 5: Consumer Rights, Ethics, and Confidentiality
CNAs and hospice aides will provide resident and client supports and services in a manner that upholds ethical and legal standards and practices while respecting the dignity, spirituality, preferences, and individuality of each person.

Competency 6: Self-Care
CNAs and hospice aides will identify ways to maintain their own physical and emotional health to address grief and loss as well as the stress and burnout associated with high quality caregiving.

Framework of desired state legislation:
The Michigan Department of Community Health shall use these core competencies to design a model curriculum to meet the federal requirements for training CNAs found at (give the citation to federal law defining CNA training) and for training hospice aides found at (give the citation to federal law defining hospice aide training).

These competencies shall be used by approved training programs and the Department to design or administer evaluations and testing of skills, knowledge, and abilities of students in approved training programs.

The design of the model curriculum shall be done in collaboration with nursing homes, hospice agencies, currently approved CNA training programs including community colleges, ISDs, high schools, and proprietary schools, advocacy organizations representing the interests for nursing home residents and hospice clients, the State Long-Term Care Ombudsman program, worker associations and organized labor who represent CNAs or hospice aides, the Department of Energy, Labor, and Economic Growth, the Office of Services to the Aging, the Michigan Direct Care Workforce Initiative, and other interested groups as identified by the Department.

The design of the model curriculum to be completed by MDCH shall include identification of specific skills, knowledge and abilities that are a competent or foundational element of the six defined competencies.

The model curriculum shall be designed with sufficient classroom, laboratory, and clinical hours and experience to meet minimum federal requirements and effectively convey the materials to students.

The model curriculum shall outline, explain, and promote the use of the principles and techniques of adult learner center education while conveying the skills, knowledge, and abilities of the core competencies.

Also, it is our recommendation that the legislation authorize MDCH to use civil monetary penalty (CMP) funds to secure necessary personnel and other resources needed to effectively and efficiently develop the model curriculum in keeping with the provisions outlined above.

Draft Administrative Recommendations for CNA/Hospice Aide Training Program 1.21.09

Michigan Model CNA Curriculum and CNA Training Program
After length consideration of a host of issues and information in 2007, the MDCWI work group concluded that students cannot be adequately prepared for caregiving work within the 2006 Michigan Model CNA curriculum. Important topics such as dementia care, person-directed planning, culture change, teamwork, and problem solving are not adequately addressed or required. And, the curriculum does not adequately foster adult-learner centered principles and activities. Therefore, the MDCWI work group recommended the adoption of state legislation to:

- Implement the recommended administrative changes described below and
- Develop a new CNA model curriculum through a collaborative process lead by the Michigan Department of Community Health.

In the summer of 2008, the Workforce Development Workgroup of the LTCSS Advisory Commission was charged to review the MDCWI recommendations. A workgroup of some 50 organizations participated in reviewing the MDWCI recommendations. This group considered changing the state's CNA program to include hospice aides working in certified hospice programs. The following recommendations are the results of the deliberations on a unified CNA/Hospice Aide enhanced training program and represent the consensus recommendations of the full Workforce Development Workgroup.

We believe that the 20-year old federal minimum standards that currently define Michigan's program CNA training and CNA registry administration no longer meet Michigan's needs for highly competent, compassionate, respected caregivers. We believe that Michigan should take advantage of the new federal Conditions of Participation for certified Hospice agencies and combine the training and administration of registration for hospice aides with certified nursing aides in nursing homes to serve the interests of consumers, caregivers, and provider organizations.

Administrative recommendations

These administrative recommendations speak to the oversight of the current CNA training program and the approved training programs, approved trainers, and the CNA registry.
Again, we recommend that this state supervised CNA training program be expanded to include hospice aides and the agencies that employ hospice aides. \
Many of the current MDCH policies that interpret federal law should be continued and bolster by state legislation or rules. Other recommendations outlined below exceed or clarify federal minimum standards in the administrative oversight of the training program. These recommendations are not currently operating within the MI CNA training program or in the training of hospice aides in hospice agencies.

1. **Approved Trainers for CNA/Hospice Aide Approved Training Programs**

   A. Primary Trainers – Maintain current federal law and MDCH policies that require Primary trainers be RNs with a minimum of 2 years of nursing experience, of which at least 1 year within the last 5 years must have been in one of the following settings: nursing home, county medical care facility, hospital long-term care unit, hospice agency, or certified home health agency.

   B. Delegated, Training Support and Guest Trainers

      i. Maintain current policy of using LPNs as Delegated trainers. LPNs must meet the same experience requirements as a primary trainer.

      ii. Recommend that a new category of trainer to be used at the discretion of the approved program. A "Training Support Assistant" may be used by an approved program and is a CNA or hospice aide with either a minimum of two years of experience within the last 5 years in any of the same settings listed for primary trainers. A training support assistant will not participate in the formal or final evaluation of student performance or competencies and will not be counted in the trainer to student ratios outlined below. A Primary and/or Delegated trainer must be in the classroom or lab and available when Training Support Instructors are teaching.

      iii. Approved programs can continue the occasional use of individual content experts to serve as "guest trainers" under the supervision of the Primary trainer to cover specific topics. Guest trainers must have at least one year's experience in their specialty field. Approved programs must notify MDCH when Guest trainers are to be used.

   C. Train-the-Trainer Program – We recommend that a Team be formed that includes current trainers, content experts and public representatives, along with an instructional designer to support them, to develop a new, expanded Train-the-Trainer (TTT) curriculum for trainers (not Coordinators), along with a timeline for introducing and requiring the new training. The new training program for primary and delegated trainers will need to give substantial attention to:

      a. Changes, if any, in the curriculum developed as a result of state legislation,

      b. Adult Learner Centered Training Methods

      c. Differences between the traditional medical model of care and person-centered care model recommended by the Michigan Medicaid Long-Term Care Task Force.

      d. The ability of "locked-out" nursing homes to host clinical placements.

      ii. The State needs to train additional TTT trainers, and offer TTT programs at more sites around the State (based on ability to fill the courses).

      iii. Delegated trainers should attend all portions of training except those that cover the regulatory and administrative content needed only by Program Coordinators and/or Primary Trainers.

      iv. Continue current MDCH requirements that Program Coordinators and Primary Trainers participate in 8 hours of training (for CEU credit) every two years, and that Primary trainers repeat the TTT Program every six years. We encourage similar educational requirements for Delegated trainers.

D. Transition to New TTT Program - We recognize that an expanded TTT program may be burdensome for some training programs and unpopular with some trainers. We recommend that incentives for participating in the expanded program or allowing experienced trainers to 'test out' of additional training be considered.

2. **Approved CNA/Hospice Aide Training Programs**

A. Online accurate database of Approved CNA/Hospice Aide Training Programs – Job seekers, career counselors, and employers need ready access to all 200+ approved CNA/Hospice Aide training programs. MDCH should establish and maintain a website listing of all approved CNA/Hospice Aide training programs with relative information and contact data. We also recommend that the state explore the legal and technological ability of approved programs to "update" their own listing rather than using state employee time.

We recommend that the listing have the following elements for each approved training program:

- Be searchable by county and zip code
- Provide eligibility criteria, if any (age, GED, drug testing, physical, etc.)
- Identify program costs and other related costs to students
- Length and frequency of the programs
- Job placement assistance, if any
- Detailed contact information on how to access more information about the approved training program

B. Online accurate database of approved Primary and Delegated Trainers – Job seekers, employers, community colleges, intermediate school districts and others need ready access to approved trainers for their CNA/hospice aide classes. MDCH should establish and maintain a website listing of all approved primary and delegated trainers with contact information. We also recommend that the state explore the legal and technological ability of approved programs to "update" their own listing rather than using state employee time. We recommend that the listing have the following elements for each approved training program:

- Be searchable by county and zip code
- Provide name, contact information for each approved primary and delegated trainer by that classification.

C. Data Collected from Approved CNA/Hospice Aide Programs – Currently, MDCH has very little data about the activities of approved CNA programs. Basic data will help develop strong a CNA/Hospice aide training program and to monitor the program outcomes.

i. We recommend that a work group, including approved training programs, clinical sites, consumer advocates, and MDCH be formed to develop a process to collect the basic data required to understand the CNA/Hospice Aide training system.

ii. We recommend the following data collection elements be collected from each approved CNA/Hospice Aide training program:

a. Enrollment numbers

b. Number of students who complete the training program

c. Drop-out number

d. Number of students passing certification test

e. Number of students completing CNA/Hospice aide training employed as CNAs in nursing homes or aides in hospice programs

f. Number completing CNA/Hospice aide training employed in other health care occupations

g. Fees charged by each training program

h. Hours/duration of the program

i. Amount of public funds spent on CNA/Hospice aide training including Michigan Works, community colleges, Medicaid and other sources.

iii. We recommend the resulting data be made widely available to nursing homes, Michigan Works! Agencies, community colleges, ISDs, nursing programs, aging and disability advocacy organizations and organized labor.

iv. Data should be collected based on a 12 month period and include all approved CNA/hospice aide training programs. The data is not intended to be used to evaluate each program but the overall training effort in Michigan.

D. Criminal Background Checks - In the last year, the scope and depth of criminal background checks done on people working in a broad range of long-term care related settings has grown. In order to reduce time and costs of training people who are ineligible due to criminal convictions and to maximize clinical placements:

i. We recommend that all CNA/Hospice Aide approved training programs be required to conduct both the state and federal criminal background checks on all applicants required by PA 26-29 of 2006 and that all applicants for training must be eligible to work under PA 26, 27, 28 and 29 of 2006 before enrollment.

ii. The costs of the criminal background checks shall be covered by state revenues and not be paid by the students or the approved training program.

iii. We recommend that the State Legislature amend relevant sections of PA 26, 27, 28, and PA 29 of 2006 to include a process that allows an individual who is ineligible to work because of criminal conviction(s) to show rehabilitation and worthiness for employment in long-term care. The evidentiary burden of demonstrating rehabilitation should be the responsibility of the applicant or job seeker.

E. Trainer to trainee ratios - The current Michigan Train-The-Trainer Manual, Chapter outlines training (class) ratios. Those ratios are Class/Lecture – not to exceed *22 trainees:1 instructor*, Lab Practice – not to exceed *12 trainees:1 instructor* and Clinical Practicum – not to exceed *8 trainees:1 instructor*. These ratios are not balanced during the three step training process (classroom, lab, and clinical) of the class. The classroom ratio should be *24:1*. Then a class of 24 could have one lecture instructor, 2 lab instructors and 3 clinical instructors working at the maximum ratio allowed. We recommend this change to 24:1 for the classroom and no changes to the other ratios.

F. Suspension of Authority to Train by Nursing Homes - Federal law prohibits or "locks- out" a nursing home, county medical care facility or hospital long-term care unit from providing their own CNA training programs when a nursing home is not in compliance with specific federal nursing facility requirements.

i. We recommend that the Federal lock-out requirement be reconsidered to allow for varying lengths of penalty related to the type and seriousness of the violation.

ii. We recommend that the Department's current waiver process and alternatives to clinical training be more clearly communicated to locked-out facilities and that more information is provided to approved CNA/hospice programs regarding the waiver process for locked-out facilities.

3. Preparation and Prerequisites for Taking the CNA/Hospice Aide Training Course

With collaboration and coordination between MDCH and the Michigan Works! Agencies funded by the MDLEG, we believe students coming to the CNA/Hospice Aide course can be better prepared for success. No legislative action seems to be required.

4. CNA/Hospice Aide Registry and Renewal Process

A. Disciplinary Process for CNA/Hospice Aide Registrants – Recommend that certified nurse aides be added to Article 15 of the Michigan Public Health Code so that the same disciplinary process used for other regulated health professionals can be applied to certified nurse aides.

i. Registry applicants should be required to respond to a series of questions at the time of application including information regarding misdemeanors and felony convictions as well as any substance abuse problems the individual has had prior to application for the registry.
ii. Positive responses to the questions would result in further review of the applicant's credentials by the Bureau of Health Professions. Individuals who are not eligible for work would be denied the ability to test and become registered.
iii. After the applicant is registered, felony and misdemeanor convictions as well as actions or complaints filed with the Department be reviewed. The Department would review the allegation and determine if a complaint should be filed and investigated against the registrant.
iv. Registrant should be formally notified of the investigation and given an opportunity to participate in an informal compliance conference or an administrative hearing.
v. Disciplinary actions that could be assessed against the registrant would include reprimand, probation, fine, limitations on employment, suspension and revocation (flag). The disciplinary actions, other than the "flag" would be for a limited time period. It would also be possible for registrants to ask for reconsideration of actions taken against them if evidence justified review.

B. CNA/Hospice Aide Registry Renewal - Continue the State's current practice of allowing verification of 8 hours of RN-supervised work to be accepted from a wide variety of long-term care health settings.

C. On-line Registration - MDCH should explore new ways to maintain information on the registry, such as allowing individual CNAs/Hospice aides to maintain their addresses on-line to ensure that current contact information is accurate for CNAs/Hospice Aides listed on the registry. This ability is likely to help with renewals of certification.

Memorandum

To: Members – Public Education / Consumer Participation Workgroup

From: Andy Farmer

Helen B. Love

Toni Wilson

Terry Eldred

Date: 2/10/2009

Re: Proposed Recommendations to LTCSS Advisory Commission

To fulfill our assignment for workgroup recommendations to the commission related to long-term care public awareness and education, we are submitting the following draft for discussion:

CASE STATEMENT

The most effective way to increase public awareness of and participation in the LTC system is through statewide implementation of the SPE program. This will require a strong, coordinated legislative campaign that must include consumer participation. Once a statewide program is enacted its success will depend on follow-up public education and a plan for its integration into all levels of Michigan's governmental and private LTC system.

> Long-term care is everybody's business, and people have two choices: Make informed (or even uninformed!) decisions and plan according to their preferences and choices, or, do nothing – and chance having choices made by others someday, including perhaps, strangers.
>
> With Executive Order 2005-14, the Department of Community Health launched Michigan's single point of entry (SPE) Demonstration program for long-term care to streamline access to LTC supports and services limited regionally, focusing on a one-stop information and resource base – now known as Michigan's Long Term Care Connections (LTCC).
>
> At four demonstration sites, the LTCCs work to promote their services – to educate and influence all those touched by long-term care issues, from consumers to legislators, and build their understanding of long-term care. Yet the success of triggering changes in behavior around planning for long-term care comes from *public education* -- letting all Michigan residents know there is one reliable, unbiased and expert place they can go to for solid advice, even as their circumstances change.

To reach and sustain the greatest depth of public awareness over the greatest period of time, and to truly achieve new person-centered, long-term care behaviors, cost-savings, and system change -- as envisioned within the Task Force Recommendations -- the SPEs must become available in every Michigan community. Only when consumers and other stakeholders no longer have to try to navigate through a fragmented system and sort through confusing and sometimes conflicting information will they be prepared to plan, execute and manage their individual choices and decisions.

The Workgroup Recommendations to the LTCSS Advisory Commission below, therefore, are based on statewide expansion of the SPE/MLTCC network, as Task Force Recommendations envisioned.

RECOMMENDATIONS

Recommendation 1: The OLTCSS should engage an external group of professionals and consumers (Action Team) to supplement the MLTCC Demonstration outreach and marketing efforts already underway.

By mid-2009, The OLTCSS should engage a broad, external group of professionals and consumers to bring an analysis of needs, requests and recommended tools which identify and fill any gaps discovered in MLTCC Demonstration outreach and marketing efforts already underway. These activity enhancements would call for and be carried out by a group comprised of targeted external stakeholders, including members of the LTCSS Advisory Commission, working together as a short-term Action Team. (See Appendix A for suggested membership and goals of Action Team)

Recommendation 2: The Action Team should assure that the SPE Legislative Expansion Campaign aligns with MLTCC Demonstration activities.

In order to maintain continuity of effort, The Action Team should assure that SPE Legislative Expansion Campaign objectives and tactics align fully with MLTCC Demonstration outreach and marketing activities, resources and tools and their iterations.

Recommendation 3: The Department of Community Health should convene an intergovernmental, stakeholder strategy team (I-Team) by September of 2009 to pursue a legislative campaign for statewide SPE expansion.

The Department of Community Health has made significant progress toward implementing the Executive Order that formed SPE's, as recommended by the Michigan Medicaid Long-Term Care Task Force Report of 2005. As the next step towards fulfilling this responsibility, the Department of Community Health should convene an intergovernmental, stakeholder strategy team (I-Team) by September of 2009. The stakeholder agencies involved should be strongly encouraged to include consumers from each of their own areas of expertise.

The Department of Community Health will lead the I-Team to conceive and launch a statewide legislative campaign for SPE expansion throughout Michigan, signed into law by the end of the 2010 legislative session. We further recommend that legislation be

based on The Model Act as furnished with the Task Force Final Report. (See Appendix B for an initial grid of possible Michigan executive branch departments, agencies and program targets for the I-Team.)

Recommendation 4: The Department of Community Health should implement a next-generation I-Team, charged to create and carry out a strategic executive branch LTC awareness and education plan.

By November 2010, or upon passage of the SPE Statewide Expansion (and version of Model Act), the Department should set and issue a new timetable (with a reasonable timeframe to implement the expansion and new SPE regions' start-ups) for reconvening and launching a next-generation I-Team, charged to create and carry out a strategic LTC awareness and education plan targeted to the state's executive branch. Membership would again draw from Appendix B and include, but not be limited to, some participants from the first I-Team. The new plan would integrate messaging with information and encourage alignment of resources in such a way as to maximize LTC quality, planning and choices across Michigan.

The new Plan would be a multi-year, open-ended effort, and the methodology for long-term leadership and ongoing management of the plan would need to be strategized, benchmarked and incorporated into the plan document and support tools. With a SPE network established and assured statewide, all state-level efforts and accountability will find their grassroots relevance and traction to make long-term care planning a part of Michigan's landscape for all residents; the desired market and population behavioral changes will thus come much closer to reality.

Appendix A

PROPOSED SHORT-TERM EXTERNAL ACTION TEAM

FOR OUTREACH AND PUBLIC EDUCATION

Membership should be drawn from:

- Communications professionals from AAAs, CILs, LTCCs, service providers, et. al.; inclusiveness is critical
- Print and electronic media reporters
- Educators, from K-12 to gerontology specialists
- Local and state government offices involved in LTC
- Communication specialists from healthcare, insurance and retirement planning industries
- Creative talent outside of LTC arena
- Specialists in use of "new media"
- Consumer advisory boards of current SPE's
- Other interested primary and secondary consumer representatives, including long-term care residents supported by distance-communication technology if necessary

Suggested Action Team Goals:

- Establish vision for a campaign
- Identify Michigan resources with existing LTC products and productions – including newsletters, websites, radio and television features, documentary films, et. al. List or collect representative samples.
- Identify all target markets (seniors, adults with physical disabilities, caregivers, policymakers, service providers, general public, et. al.)
- Prioritize target markets
- Identify links to reach target markets (mass media, faith community, businesses, and insurance, elder law, and financial planning specialists, consumer coalitions and groups, et. al.)
- Outline plan to design key messages
- Project costs of statewide media blitz
- Determine next steps, from maximizing existing sources of talent and funding to seeking new funding, perhaps from foundations

Appendix B

STATE EXECUTIVE BRANCH

POSSIBLE PUBLIC AWARENESS CAMPAIGN TARGETS

DEPARTMENT	POSSIBLE PROGRAMS, SERVICES & AGENCIES
Agriculture	Food Supplies, Safety, Commodities, Emergency Preparedness, Gardening Projects (Nutrition Capacity, Planning, Education & Access themes), Consumers
Arts, History & Libraries	Public, Schools & Colleges library networks, resources and programs, historical research grants and programs, artistic grants, exhibits and rehabilitative collaboratives
Attorney General	Consumer Rights, Protection, Reporting, Prosecution, Law Enforcement Coordination, Consumer Advocacy Resources
Civil Rights	Racial Disparities in Health, Disability Rights, Employment Rights
Community Health	Mental Health & Substance Abuse, Chronic Diseases, Health Information Technology* (+ Commission), Medical Services (+ Medicaid), Licensing (Hospitals, Nursing Facilities, Health Professions), County/Local Health Services, Aging Programs & Services, Consumer Advisory Board members from existing SPE's, other consumers receiving department services
Corrections	Array of Health, Mental Health, Substance Abuse Treatment and LTC services and settings
Education	Career Education, Curricula & Instruction Development, School Nutrition Services, Programs and Training, School Health & Safety Initiatives, Early Intervention Programs
Human Services	Array of Assistance Programs and Adult Services, Home Help, Licensing (AFC-HFA), Emergency & Crisis Services, Community Action/Anti-Poverty Programs, Applications Assistance, Consumers using department services
Information Technology	Technology Focus Areas, Health Information Technology Initiative*
Military & Veterans Affairs	Limited array of health benefits, "domicillary" and disability coverage, 2 Nursing Facilities (Grand Rapids, Marquette),
Transportation	Mobility Options, Intermodal Concerns, Public Participation Plan
Labor & Economic Growth	Building Construction Codes (Universal Design, "Zero-Step" themes), Career Education (Adult Education, Post-Secondary Education), Workforce Investment, Regional Skills Alliances, Rehabilitation Services, Commissions for Blind, Deaf/Hard of Hearing, Disabled, Housing Development Authority, Employment Definitions & Data Warehouse, Insurance Licensing & Regulation

***** currently hospital-acute care systems only

January 30, 2009

Dear Legislator:

The Long Term Care Supports and Services Advisory Commission is deeply concerned about the quality, availability and affordability of long term care services in our state. In these tough economic times, as you struggle with budget shortfalls, we urge you to keep the current and future needs of those touched by the need for long-term care – in other words, virtually every Michigan family – in mind.

Long-term care spans a range of settings, from care in a person's home to care in skilled nursing facilities to small group adult foster care homes and assisted living. Quality long-term care services allow people with disabilities and older people to live full lives. These services are very different from hospital and physician services, which are short term and focused on "cures;" long-term care is focused on supports, often including rehabilitation care, and on consumer choice and control.

Even though individuals pay for much of the long-term care they receive, public funding is critical if Michigan families are to have access to a full array of services. For example, most people using nursing home care pay their own way until their saving are gone, then must rely on Medicaid to help them pay for their care. "Marge" (names changed) has lived in a Grand Rapids nursing facility for three years, paying with her own savings. This October, her savings were depleted and she applied for Medicaid. Marge has spent over $200,000 of her own money for care, and now most of her monthly income of $1,209 will be paid to the facility, with Medicaid paying the balance each month. Marge needs the publicly funded support of Medicaid to continue living and being supported in the nursing facility of her choice.

People using supports in their own homes often rely on a combination of paid caregivers, volunteer support, and publicly funded services. "Fred" has lived in his Southeast Michigan apartment for 12 years. Fred is 55 and has several physical disabilities. His wife and caregiver suddenly died last year, and Fred needs more support from formal programs than when she was living. Fred's income is below the $1,911 limit for MI Choice, but there is a long waiting list for that program in his area. Fred is not getting the support he needs, and his health is beginning to deteriorate from a lack of daily assistance. He needs an adequately-funded MI Choice program if he is to maintain his life.

Marge, Fred and the tens of thousands of other Michigan citizens who rely on long-term care services need to know that those services will be there for them tomorrow. With the number of citizens needing long-term care increasing – it is expected to double over the next 20 years – we cannot rely on short-term budget fixes. We need a state revenue base that is adequate to meet our current unmet needs, and will grow as the need grows.

Simply put, we cannot cut our way out of this dilemma. More workers are needed to provide care, and more staff at the Department of Human Services are essential to establishing eligibility and access to publicly funded Long Term Care services. (DHS numbers here)

The good new is that Long Term Care supports and services are a growth sector in our economy. There will be more jobs and more opportunities for the next generation of workers in this sector. (PHI statistics here)

Even if a federal stimulus package provides some relief to Michigan, Long Term Care planning will require thoughtful work from you in developing a plan for the next 10 years in Michigan. Reacting to each year's budget woes has not resulted in long range plans for Michigan's future. We challenge you as policy makers to plan for the growth in Long Term Care, to invest in the safety net of publicly funded Long Term Care, to invest in training and re-training programs so that workers are qualified and ready to work in this field, and to look at public funding as not only an investment in the safety net, but as a building block to Michigan's economic recovery.

The Long Term Care Supports and Services Commission looks forward to working with you in designing and planning for Michigan's future in Long Term Care.

Sincerely,

[Draft furnished by Commissioners Slocum, Ewing and Chaney]